SNYDER VILLAGE HEALTH CENTER
APPLICATION FOR RESIDENCY

1200 East Partridge St., Metamora, Illinois 61548 | (309) 367-4300

DATE _____

Please complete the following information for Applicant.

Applicant_____ _____ _____ _____
First **Middle Initial** **Last** **Maiden**

Preferred Name *(if different from above)* _____

Social Security #_____ Medicare # _____

Birth Date _____ Age_____ Sex_____ Marital Status: S___ M___ W___ D___

Birth Information: City _____ County _____ State _____

Present Home Address: _____ _____
Street **City/State** **Zip** **Current Telephone**

Spouse (Even if Deceased): _____ _____ _____ _____
First **Middle Initial** **Last** **Maiden**

PERSON WHO SHOULD RECEIVE STATEMENT (GUARANTOR):

Name _____ Relationship_____

Address _____ City _____ State _____ Zip_____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Name of Power of Attorney for Health Care _____ Phone _____

Address _____ City _____ State _____ Zip_____

Name of Power of Attorney for Financial _____ Phone _____

Address _____ City _____ State _____ Zip_____

GUARANTOR CONTINUED

Name of Legal Guardian _____ Phone _____

Address _____ City _____ State _____ Zip_____

APPLICANT:
CONTACT INFORMATION

Primary Emergency Contact:

Name _____ Relationship_____

Address _____ City _____ State _____ Zip_____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Alternate Emergency Contact:

Name _____ Relationship_____

Address _____ City _____ State _____ Zip_____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Other Emergency Contact:

Name _____ Relationship_____

Address_____ City _____ State _____ Zip_____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

MEDICAL INFORMATION

Current Primary Physician _____ Office Phone _____

Primary Physician While at S/V _____ Office Phone _____

MEDICAL INFORMATION CONTINUED

Address _____ City _____ State _____ Zip_____

Specialist _____ Specialty_____

Address _____ Office Phone _____

Dentist _____ Office Phone _____

Eye Doctor _____ Office Phone _____

Hospital Preference _____ Phone _____

Funeral Home Preference _____ Phone _____

Do you have a living will? Yes ____ No ____

I DO _____ DO NOT _____ wish to have CPR procedures performed on me while a resident at Snyder Village.

SOCIAL INFORMATION

Have you ever been convicted of a felony? Yes ____ No ____

Race _____ U.S. Citizen Yes ____ No ____ U.S. Veteran Yes ____ No ____

Is/was your spouse a veteran? Yes ____ No ____

Mother's Maiden Name _____ Father's Name _____

Lifetime Occupation _____ Date of Retirement _____

	Grade School	**High School**	**College**
Education: Highest Grade Completed:	1 2 3 4 5 6 7 8	9 10 11 12	1 2 3 4

Post Graduate _____ Tech/Trade School _____

Religion _____ Church Affiliation _____

Clergy_____ Phone _____

Has a Burial Trust been established? Yes ____ No ____ Value $_____

INSURANCE INFORMATION

Do you have alternative a Medicare Advantage Policy? Yes ____ No ____

Name of insurance company _____

Address _____ City _____ State _____ Zip_____

Phone _____ Policy #_____

Do you have any Medicare Supplemental Health Insurance? Yes ____ No ___

Name of insurance company _____

Address _____ City _____ State _____ Zip_____

Phone _____ Policy #_____

Do you have Medicare D (Drug) coverage? Yes ____ No ____

Name of insurance company _____

Address _____ City _____ State _____ Zip_____

Phone _____ Policy #_____

Do you have any employer provided insurance? Yes ____ No ___

Name of insurance company _____

Address _____ City _____ State _____ Zip_____

Phone _____ Policy #_____

Do you have any Long-Term Care Insurance? Yes ____ No ___

Name of insurance company _____

Address _____ City _____ State _____ Zip_____

Phone _____ Policy #_____

Daily Benefit Amount _____ Duration of Benefit _____

FINANCIAL INFORMATION
Sources of Income

	Monthly
Social Security Applicant	$ _____
Spouse	$ _____
Pension Applicant	$ _____
Spouse	$ _____
Interest Income	$ _____
Rental Income	$ _____
Dividends	$ _____
Bonds	$ _____
Other sources of income	$ _____

Bank Accounts
Please include the name(s) and relationship to you of anyone whose name(s) is/are on your account(s).

	Institution	Account #	Current Balance
Savings	_____	_____	$ _____
	_____	_____	$ _____
Checking	_____	_____	$ _____
	_____	_____	$ _____
CD/Money Market	_____	_____	$ _____
	_____	_____	$ _____
Other	_____	_____	$ _____

Real Estate
Do you own your own home? Yes _____ No _____ How long? _____

Approximate Value $ _____

Outstanding Mortgage $ _____

Lender _____

Other real estate owned and approximate value _____

Life Insurance policies

Company _____ Cash Value $ _____

Company _____ Cash Value $ _____

Stocks/Bonds, Mutual Funds, IRA's, 401K, etc.

Company / Fund Name _____ Estimated Value $ _____

Company / Fund Name _____ Estimated Value $ _____

Company / Fund Name _____ Estimated Value $ _____

Company / Fund Name _____ Estimated Value $ _____

Trusts
Do you have a trust? Yes _____ No _____

If yes, is it revocable or irrevocable? Please circle and list amount $ _____

Any Other Assets or Sources of Income

Description_____

Amount $ _____

Obligations: *(Please list any debts, mortgages, obligations, etc., affecting your income or assets.)*

_____

Amount $ _____

Do the names of any other individuals appear on any of the above accounts? Yes _____ No _____

Within the past 60 months, have you or your spouse sold or given away assets; closed any bank accounts; or made any changes in the way an asset is held (such as adding a name to a house deed or creating a trust or annuity?) Yes _____ No _____

Within the past 60 months have you or your spouse: 1) Made any transfers from a revocable trust, or 2) created an irrevocable trust that does not permit payment to you? Do you or your spouse have an irrevocable trust that has stopped payment within the past 60 months? Yes _____ No _____

If you answer yes to either of these questions, please specify transactions made.

_____

_____

_____

_____

IMPORTANT: PLEASE BRING IN THE FOLLOWING FOR DUPLICATION, OR ATTACH A COPY

1. Medicare Card (Red, white and blue card)
2. Social Security Card
3. Other Health Insurance Identification Cards
4. Financial Power of Attorney, Guardianship Conservatorship, or Bank Trust Papers
5. Health Care Power of Attorney / Living Will

AGREEMENT INFORMATION: RETIREMENT COMMUNITY

I (we) further certify that all assets and income amounts are available for the use of the applicant(s) to be applied to expenses incurred by me (us) for any services provided by any entity of snyder village.

I (we) understand that my (our) submission of this application for residency at Snyder Village is not binding.

I (we) hereby give authorization to Snyder Village to review and discuss the intent of my (our) application with my family, physician and contact persons listed above.

I (we), the undersigned, do hereby certify that the answers to the foregoing questions are true, correct, and complete to the best of my (our) knowledge. I (we) further certify that all assets and income amounts are available for the use of the applicant(s) to be applied to expenses incurred by me (us) for any services provided by any entity of Snyder Village. I (we) do hereby authorize investigation of any statement contained in this application by Snyder Village or its agent. I (we) understand that a misrepresentation or omission of facts may be the basis for denying applicant(s) admission to or for discharge from Snyder Village. To insure payment to Snyder Village of any charges due, resident(s) or responsible party shall cooperate fully in furnishing Snyder Village any necessary financial, medical or other required information necessary for determination of eligibility for any aid or assistance program. I (we) or re-

sponsible party will further cooperate in the preparation, filing, signing, etc, of necessary applications, reports, or documents for any program or other purpose necessary or required by any government agency. Further, the I (we) or responsible party authorizes the release of information from any financial, housing or other institution necessary to make eligibility determinations.

Date **Applicant**

Responsible Party

TO WHOM IT MAY CONCERN:

The following paragraphs provide the assignment of health insurance benefits and the release of certain information, which is required by Snyder Village Health Center of Metamora, Illinois.

I acknowledge that this information will be considered confidential by Snyder Village and its agents and will not be transferred to any other person without first obtaining my written consent. I further declare that a photocopy of this authorization shall be considered as effective and valid as the original.

AUTHORIZATION FOR RELEASE OF INFORMATION AND MEDICAL RECORDS

I hereby authorize my insurance company of companies to release information regarding the insurance benefits to which I am entitled for any medical, long term care, or supplemental health insurance benefits policy currently in effect. This information includes, but is not limited to, the scope and limits of coverage, possible exclusions, and effective date(s).

ASSIGNMENT OF BENEFITS

For any medical services or supplies provided to me by Snyder Village, I authorize Snyder Village Health Center to bill Medicare and/or my insurance on my behalf. I also assign all Medicare and/or health insurance benefits due or payable to me to be paid to Snyder Village Health Center from the date of my admission or from this date forward, whichever is applicable.

Applicant **Date**

Legally Authorized Representative